Date of Hearing: May 18, 2020

ASSEMBLY COMMITTEE ON HEALTH
Jim Wood, Chair
AB 2164 (Robert Rivas) – As Amended May 11, 2020

SUBJECT: E-Consult Services and Telehealth Assistance Program.

SUMMARY: Establishes the E-Consult Services and Telehealth Assistance Program within the State Department of Health Care Services (DHCS) to award grants to eligible specified health clinics to conduct projects to implement and test the effectiveness of e-consult services and related telehealth services. Prohibits face-to-face contact between a health care provider and a Medi-Cal eligible patient from being required for a federally qualified health center (FQHC) or rural health clinic (RHC) to establish a patient at any time, including during an initial telehealth visit, or to render and bill for services by telehealth, subject to specified requirements. Specifically, **this bill**:

1) Allows DHCS to award grants to eligible health center-controlled networks, health centers, and RHCs to conduct projects to implement and test the effectiveness of e-consult services and related telehealth services furnished at those networks, centers, and clinics for purposes of addressing the objectives described in 3) below.

2) Requires funding for the grant program to be contingent upon an appropriation in the annual Budget Act.

3) Requires grants awarded pursuant to 1) above to address the following objectives:
   a) Improve patient access to specialty care;
   b) Reduce specialty care patient wait times;
   c) Reduce patient specialty referrals;
   d) Reduce patient miles traveled for specialty care consultations;
   e) Increase support for primary care physicians and other providers of primary care as demonstrated by job satisfaction measures;
   f) Increase patient satisfaction as demonstrated by quality surveys;
   g) Increase health care cost savings; and,
   h) Other objectives DHCS may identify.

4) Requires a grant awarded in 2) above to be no more than five years.

5) Requires grant funding awarded to a health center-controlled network, health center, or RHC in 1) above to be used only for the following:
   a) Conduct assessments of a participating facility's infrastructure, including broadband, equipment, and software, clinical objectives, and staffing plans;
   b) Develop and assist in the execution of equipment and software procurement, defining clinical objectives, developing adequate staffing plans, and implementing e-consult services and related telehealth services program plans based on assessment findings;
   c) Train participating facility staff to properly utilize technology and implement programs;
   d) Provide clinical workflow training to support program implementation;
   e) Provide integrated certified electronic health record (EHR) technology capabilities to support live video, if applicable, and e-consult services;

f) Integrate the facility with live e-consult service support providers and networks that meet the patient objectives of the network, center, or clinic;
g) Procure appropriate information technology and undertaking minor alterations of physical space; and,
h) Carry out the project to address the objectives described 1) above.

6) Requires a location of a health center or RHC to qualify to participate in a program established in this bill if they can sufficiently demonstrate that the location meets both of the following criteria:
   a) Lacks sufficient access to care provided by specialists; and,
   b) Has not already implemented a program of e-consult services and related telehealth services similar to that described in this bill.

7) Requires an entity, to be eligible to receive a grant pursuant to 1) above, to:
   a) Be either of the following:
      i) A health center-controlled network that demonstrates, to the satisfaction of DHCS, all of the following:
         (1) Sufficient expertise and experience in the successful provision of the technical and other assistance required for health centers and RHCS to conduct a project in accordance with this bill;
         (2) Evidence of sufficient binding participation commitments received from eligible health centers and RHCs;
         (3) The ability to assist eligible health centers and RHCs to conduct e-consult services with specialists and related telehealth services; and,
         (4) A likelihood of successfully accomplishing the program objectives as identified in 2) above; or,
      ii) A health center or RHC that demonstrates, to the satisfaction of DHCS , all of the following:
         (1) Sufficient expertise and ability to implement on its own behalf the technical and other assistance required to conduct a project in accordance with this section;
         (2) A likelihood of successfully implementing a program of e-consult services with specialists and related telehealth services; and,
         (3) A likelihood of successfully accomplishing the program objectives as identified in 2) above.
   b) Submit to DHCS an application in a form and manner as determined by DHCS. Requires application to demonstrate, to the satisfaction of the DHCS, all of the following:
      i) In the case of an applicant that is a health center-controlled network, the intention of a sufficient minimum number of eligible health centers to participate in the program through the network and a plan for recruiting additional centers to participate;
      ii) The qualification of proposed facility locations that will participate in the program;
      iii) The requisite experience, expertise, and capacity;
      iv) The likelihood of successfully accomplishing the program objectives as identified in 2) above;
      v) The internal program metrics that will be employed to demonstrate satisfaction of the program objectives and the information to be collected and provided to DHCS as necessary to conduct a program evaluation.
   c) Requires DHCS, no later than 180 days after the date of completion of the last projects funded under this bill, to submit to the Legislature a report, including an evaluation, on the projects that addresses all of the following:

i) An overview of supported projects and identification of areas of success and failure;
ii) Policies, practices, and organizational approaches that either facilitate or impede the effective use of e-consult services, including personnel training and support, technology usability, workflow, and provider communication;
iii) Relative effectiveness of consultations provided by specialists in improving outcomes, quality of care, and efficiency with respect to different specialties, clinical conditions, complexity, patient types, or other issues;
iv) The extent to which information shared in the e-consult services process is sufficient, accurate, and actionable to effectively facilitate care improvement, and whether those bidirectional information flows can be standardized;
v) The extent to which e-consults facilitate continuity of care;
vi) Any issues arising related to maintaining the privacy of personal health information, ensuring cybersecurity, and other information security issues;
vii) The extent to which e-consult services contribute to improved health outcomes and metrics that can facilitate that evaluation; and,
viii) Any unintended or adverse results from utilizing e-consult services.

8) Defines various terms, including the following:
   a) Certified EHR technology as a qualified electronic health record, as defined in federal law.
   b) E-consult service as synchronous or asynchronous, consultative, health-care-provider-to-health-care-provider communications that occur within a shared certified EHR technology or secure internet-based platform and primarily intended to provide specialty expertise to treating clinicians without requiring a direct interaction between the patient and the specialist. Involves a treating clinician sending information regarding the patient and a consultation request to a specialist, who may then respond in any of a number of ways, including providing requested feedback, asking for additional information, recommending certain studies or examinations, or initiating the scheduling of an appointment.
   c) Health center as a center as defined in federal law.
   d) Health center-controlled network as a network that is owned and controlled by health centers, as described in federal law.
   e) Related telehealth services as telehealth services arising out of or incident to an e-consult service, such as laboratory tests, diagnostic imaging, or a later interaction between a specialist and a patient.
   f) RHC as a clinic as defined in federal law.
   g) Telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care. Telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers, consistent with existing law.

9) Requires, if FQHC services and RHC services involve telehealth by synchronous real time or asynchronous store and forward, all of the following to apply:

10) Prohibits face-to-face contact between a health care provider and a Medi-Cal eligible patient, from being required for the FQHC or RHC to establish the patient at any time, including during an initial telehealth visit by synchronous real time or asynchronous store and forward,

as a patient of record of the FQHC or RHC or to render and bill for services by telehealth synchronous real time or asynchronous store and forward services, if all of the following requirements are met:

a) A licensed non-billable Medi-Cal provider, who is employed by the billing FQHC or RHC, is physically present with the patient at the originating site, as defined in existing law;
b) The billing provider is also an employee of the FQHC or RHC;
c) The patient is at an originating site that is a licensed FQHC or RHC or an intermittent clinic site of the FQHC or RHC, and is located within the FQHC's or RHC's federally designated service area; and,
d) A billable provider in the Medi-Cal program, and who is employed by the FQHC or RHC, supervises or provides the health services for that patient via telehealth by synchronous real time or asynchronous store and forward.

11) Permits a patient relationship with the FQHC or RHC to be established at any time, including during an initial visit that includes telehealth by synchronous real time or asynchronous store and forward.

12) Defines, for purposes of FQHC and RHC reimbursement provisions under what is known as the Prospective Payment System (PPS), an FQHC or RHC "visit" to include a visit using telehealth by synchronous real time or asynchronous store and forward.

13) Defines a "patient" as an individual enrolled in the Medi-Cal program who may or may not have an established patient of record relationship with the FQHC or RHC.

14) Permits DHCS to implement, interpret, and make specific the Medi-Cal telehealth provisions of this bill by means of all-county letters, provider bulletins, and similar instructions.

EXISTING LAW:

1) Establishes the Medi-Cal program, which is administered by DHCS, under which qualified low-income individuals receive health care services, as specified. Requires FQHC and RHC services to be covered benefits under the Medi-Cal program.

2) Requires FQHCs and RHCs to be reimbursed on a per-visit basis. Defines a "visit" as a face-to-face encounter between an FQHC or RHC patient and the following health care providers: a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker, visiting nurse, podiatrist, dentist, optometrist, chiropractor, comprehensive perinatal services practitioner providing comprehensive perinatal services, a dental hygienist, a dental hygienist in alternative practice, or a marriage and family therapist, a four-hour day of attendance at an Adult Day Health Care Center; and, any other provider identified in the state plan's definition of an FQHC or RHC visit.

3) Provides that in-person contact between a health care provider and a patient is not required under the Medi-Cal program for services appropriately provided through telehealth, as defined, subject to reimbursement policies adopted by DHCS to compensate a licensed health care provider who provides health care services through telehealth that are otherwise reimbursed under the Medi-Cal program. Prohibits, for purposes of payment for covered

treatment or services provided through telehealth, DHCS from limiting the type of setting where services are provided for the patient or by the health care provider.

4) States legislative intent to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the provider. Prohibits a health plan or health insurer from requiring in-person contact between a health care provider and a patient before payment is made for the covered services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the enrollee and the health plan or the insured and health insurer, and between the health plan or health insurer and its participating providers or provider groups.

5) Defines the following:
   a) Telehealth as the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site. States that telehealth facilitates patient self-management and caregiver support for patients and includes synchronous interactions and asynchronous store and forward transfers.
   b) Originating site as a site where a patient is located at the time health care services are provided via a telecommunications system or where the asynchronous store and forward service originates.
   c) Synchronous interaction as a real-time interaction between a patient and a health care provider located at a distant site.
   d) Asynchronous store and forward as the transmission of a patient's medical information from an originating site to the health care provider at a distant site without the presence of the patient.
   e) Distant site as a site where a health care provider who provides health care services is located while providing these services via a telecommunications system.

6) Defines in federal law the following:
   a) Health center as an entity that serves a population that is medically underserved, or a special medically underserved population comprised of migratory and seasonal agricultural workers, the homeless, and residents of public housing, by providing, either through the staff and supporting resources of the center or through contracts or cooperative arrangements.
   b) Certified EHR technology as a qualified electronic health record that is certified as meeting standards adopted under federal law that are applicable to the type of record involved (such as an ambulatory electronic health record for office-based physicians or an inpatient hospital electronic health record for hospitals).
   c) Rural health clinic as a facility which is primarily engaged in furnishing to outpatient services as described; maintains clinical records on all patients; and, has arrangements with one or more hospitals for the referral and admission of patients requiring inpatient services or such diagnostic or other specialized services as are not available at the clinic.

FISCAL EFFECT: This bill has not yet been analyzed by a fiscal committee.

COMMENTS:

1) **PURPOSE OF THIS BILL.** According to the authors, California's community health centers serve the state's most vulnerable populations. One in six Californians are seen in an FQHC in California today for their healthcare needs and one in three of these patients are covered by Medi-Cal. The COVID-19 pandemic has underscored the importance of utilizing telehealth to ensure the delivery of reliable care to the most vulnerable populations and underserved areas of the state. Telehealth has proven to be an invaluable tool to ensure that patients, especially those who are low-income and living in underserved areas, get the medical, dental, and mental healthcare they need. Health centers are recognized as central to primary care delivery in California and need to be supported to integrate virtual care innovation and technology into their clinical workflow and assist with staff and provider education and training. It is essential that we make it easier to provide care to people who wouldn't get it otherwise.

   The authors point out that expanding access to E-Consult services for safety net providers is showing great promise to improve access to specialty care for patients, increase patient satisfaction, support primary care providers in underserved communities and has demonstrated cost savings. Through this bill, California will create and invest in the E-Consult program, improving healthcare access via an accessible and cost-effective program. The authors conclude that this bill would also expand access for the most vulnerable populations by enabling FQHCs and RHCs, which are critical sources of care that serve as safety net for the most vulnerable populations, to establish patients via telehealth at community sites, such as schools, early learning sites and nursing homes.

2) **BACKGROUND.**

   a) **FQHCS and RHCS.** FQHCs and RHCs are federally designated clinics that are required to serve medically underserved populations that provide primary care services. There are over 1,000 FQHCs and approximately 283 RHCs in California. Medi-Cal reimbursement to FQHCs and RHCs is governed by state and federal law. FQHCs and RHCs are reimbursed by Medi-Cal on a cost-based per-visit rate under the PPS. For Medi-Cal managed care plan patients, DHCS reimburses FQHCs and RHCs for the difference between its per-visit PPS rate and the payment made by the plan. The mean and median PPS rate paid to an FQHC and an RHC is considerably higher than the most common primary care visit fee-for-service reimbursement rates in Medi-Cal.

   b) **Medi-Cal.** DHCS considers telehealth a cost-effective alternative to health care provided in-person, particularly to underserved areas. Telehealth is not a distinct service, but a way that providers deliver health care to their patients that approximates in-person care. The standard of care is the same whether the patient is seen in-person or through telehealth. DHCS's coverage and reimbursement policies for telehealth align with the California Telehealth Advancement Act of 2011 and federal regulations. State law defines telehealth as "the mode of delivering health care services and public health via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care while the patient is at the originating site and the health care provider is at a distant site." Medi-Cal complies with federal regulations for telehealth, which are the same for Medicaid as they are for Medicare. Medicaid regulations authorize telehealth using "interactive communications" and asynchronous store and forward technologies. Interactive telecommunications must include, at a minimum, audio and video equipment permitting real-time two-way communication, according to the Centers for

Medicare and Medicaid Services (CMS).

DHCS recently revised the Medi-Cal telehealth policy to allow providers increased flexibility in their use of telehealth as a modality for delivering medically necessary services to their patients. The policy is effective July 1, 2019, and fee-for-service providers must submit claims for services provided via telehealth according to the new policy. However, DHCS has a more restrictive telehealth policy for FQHC and RHCs, as described below.

c) Telehealth policies for FQHC and RHCS. In February 2020, DHCS revised its Medi-Cal FQHC and RHC reimbursement policies in its Provider Manual for telehealth, with separate telehealth guidance for FQHCs and RHCs. For FQHCs and RHCs, the policies define what is an "established patient" for purposes of telehealth policy as one or more of the following:

i) The patient must have a health record with the FQHC or RHC that was created or updated during a visit that occurred in the clinic or during a synchronous telehealth visit in a patient's residence or home with a clinic provider and a billable provider at the clinic. The patient's health record must have been created or updated within the previous three years.
ii) The patient is homeless, homebound or a migratory or seasonal worker (HHMS) and has an established health record that was created from a visit occurring within the last three years that was provided outside the originating site clinic, but within the FQHC's or RHC's service area. A consent for telehealth services for these patients must be documented.
iii) The patient is assigned to the FQHC or RHC by their Medi-Cal managed care plan pursuant to a written agreement between the plan and the FQHC or RHC.

DHCS guidance prohibits a patient from being "established" on an asynchronous store and forward service, with the exception of HHMS. This bill would change this and instead permit an FQHC or RHC to establish a patient at any time, including during an initial telehealth visit by synchronous real time or asynchronous store and forward, or to render and bill for services by telehealth synchronous real time or asynchronous store and forward services, subject to specified requirements, thereby over-riding several DHCS telehealth policy restrictions for both asynchronous store and forward and synchronous interactions.

As described below, DHCS has requested a waiver of the "established patient" requirements via a Section 1135 waiver and State Plan Amendment.

This telehealth policy change would enable the Virtual Dental Home program to be used for patients who are not established patients of the FQHC. Under the Virtual Dental Home, a registered dental assistant (RDA), registered dental hygienist (RDH) or RDH in alternative practice (RDHAP) used portable imaging equipment and an internet-based dental record system to collect electronic dental records such as X-rays, photographs, charts of dental findings, and dental and medical histories, and uploads the information to a secure website, where they are reviewed by a collaborating dentist. The dentist reviews the patient's information and creates a tentative dental treatment plan. The RDHAP, RDH or RDA then carries out the aspects of the treatment plan that can be conducted in the

community setting. After the dentist reviews the electronic dental records, the RDHAP, RDH or RDA refers patients to dental offices for procedures that require the skills of a dentist. However, the allied dental professionals in the HWPP 172 demonstration project were allowed to place interim therapeutic restorations (ITRs are temporary filings) under general supervision of dentists. When these visits occur, the patient arrives with health history and consent arrangements completed, a diagnosis and treatment plan already determined, preventive practices in place and preventive procedures having been performed.

AB 1174 (Bocanegra), Chapter 662, Statutes of 2014 codified the scope of practice expansion of certain allied dental professionals and prohibited Medi-Cal from requiring a face-to-face visit between a patient and provider before allowing for teledentistry services as a Medi-Cal billable service. However, the established patient requirement for FQHCs limits the use of teledentistry as dental hygienists performing x-rays and transmitting them via "store and forward" and treating children in a school-based setting is not reimbursable if they are not an established patient of the FQHC.

In addition to the Medi-Cal telehealth provisions, this bill would create a grant program that will support the telehealth infrastructure necessary to implement effective e-Consult programs at FQHCs and RHCs, thereby improving access to care for medically underserved populations. Additionally, the author notes e-Consults can also dramatically lower costs for both patients and payers. For patients, the cost savings can be seen through the reduction of expenses for childcare, transportation, or time lost at work. Cost savings for payers can vary greatly, particularly when factoring in avoidance of an emergency department visit. According to Health Affairs, a case study performed on an e-Consult program implemented in Connecticut showed that on the payer side the average cost of an e-Consult, as opposed to a face-to-face consultation, was $84 lower per patient, per month, resulting in annualized Medicaid savings of $578,592. In a time of ever-rising healthcare costs, e-Consults have the potential to mitigate costs while improving and streamlinin the patient and provider experience. Health Affairs notes that the increase in specialty referrals for patients with Medicaid makes a substantial contribution to year-over-year health care cost increases and has significant economic consequences for state budgets. Specialty care is significantly more expensive than primary care. Limited access compounds the problem by delaying needed treatment and increasing the use of urgent care and emergency departments.

d) State Section 1135 Waiver Request and State Plan Amendment Request. On March 26, 2020, DHCS wrote to the Centers for Medicare and Medicaid Services requesting approval for the multiple detailed additional flexibilities under Section 1135 of the Social Security Act. When the President declares a disaster or emergency under the Stafford Act or National Emergencies Act and the federal Department of Health and Human Services (DHHS) Secretary declares a public health emergency, the Secretary of DHHS is authorized to take certain actions in addition to her regular authorities. For example, under Section 1135 of the Social Security Act, they may temporarily waive or modify certain Medicare, Medicaid, and Children's Health Insurance Program requirements to ensure that sufficient health care items and services are available to meet the needs of individuals enrolled in Social Security Act programs in the emergency area and time periods and that providers who provide such services in good faith can be reimbursed and exempted from sanctions.

Related to this bill, DHCS requested a waiver of the face-to-face encounter requirement for reimbursement in specified federal regulations relative to covered services via telehealth provided by clinic providers, and to allow flexibility to provide these covered services via telehealth without regard to date of last visit and for new or established clinic patients.

DHCS followed up on April 3, 2020, with a letter to CMS requesting a State Plan Amendment (SPA) 20-0024, requesting, when the treating health care practitioner of the FQHCs/RHCs satisfies all of the procedural and technical components of the Medi-Cal covered service or benefit being provided except for the face-to-face component, reimbursement to occur to an FQHC or RHC at the PPS rate for new or established patients, irrespective of date of last visit. DHCS seeks to align this SPA with the duration of the emergency period, starting with the effective date of March 1, 2020.

e) Budget request. One of the author sand one of the sponsors also submitted a 2020-2021 Budget Proposal which would create and fund the eConsult Services and Telehealth Assistance Program and provide FQHCs and RHCs with the tools necessary to implement an eConsult program. These tools include technical assistance, health center clinical workflow development, and staff education and training aimed at improving access to specialty care. The eConsult program will expand network adequacy by increasing access to specialty care through telehealth without decreasing quality of care. The funding requested for this grant program is $7.5 million.

3) SUPPORT. OCHIN INC., sponsors of this bill, states that eConsult services have the potential to dramatically impact healthcare delivery within primary care by allowing primary care providers to access a virtual specialty care consultation in a timely manner. These consultations provide the opportunity for a primary care provider to confirm the need for a referral, or even avoid one deemed unnecessary, saving the patient time and reducing overall costs. This virtual connectivity allows for greater collaboration and improved communications between providers, resulting in better care coordination. These consultations also help to educate primary care providers, allowing them to deliver care at the top of their practice. The Los Angeles Trust for Children's Health writes that Medi-Cal beneficiaries continue to lack access to specialty care, as described in the DHCS's recently published 2017-18 Access Assessment. E-consult offers a foundational strategy to alleviate specialty access issues, in addition to improved provider work quality and satisfaction, and cost savings for the health system. Research out of Los Angeles County Department of Health Services (DHS) found that 25% of e-consults performed within the DHS clinic network were resolved without the need for a follow-up in-person visit over the period 2012 to 2015.

Additionally, this bill is jointly sponsored by CaliforniaHealth+Advocates, the California Dental Association, the Children's Partnership and Children Now, which write that with an expansion of telehealth, California can further address access barriers for children by ensuring community health centers are able to bring care to where children are, through innovative solutions like telehealth. Rapidly advancing telehealth models use technology to bring high-quality and safe care to children at schools, early learning centers, and other community sites where they spend time. Community health centers are critical sources of care in California, serving as a health care safety net for the most vulnerable populations. Supporters argue this bill supports health centers' ability to establish and serve patients by

bringing health care to safe and trusted community sites within their designated service areas—such as schools and early learning sites—using effective telehealth models.

The sponsors state, one evidence-based example is the VDH, in which specially trained dental hygienists and assistants go to schools and other community sites to provide diagnostic, preventive, and early intervention dental care in partnership with a collaborating dentist. A six-year study of the VDH model, in which almost 3,500 individuals were seen in 50 community sites across California, found that the majority of patients could receive all of the care they needed at the community location. Additionally, parents do not need to take time off of work and a child does not need to miss school to get timely and needed care. When schools across California reopen after this time of emergency, students will need access to mental and behavioral health resources more than ever. In recent years, the Legislature has looked to telehealth as one key strategy in addressing the barriers faced by students in accessing mental and behavioral health care in their communities. This bill will ensure that as the need for care delivered via telehealth continues to grow, we will have policies in place to support these innovative solutions to provide safe, high-quality care to California's most vulnerable populations. They conclude that this bill has the potential to increase access to vital and cost-effective health care services to thousands of children in underserved communities across California during times of crisis and always.

4) **SUPPORT IF AMENDED.** The California Association of Physician Assistants write that by law, physician assistants (PAs) work in collaboration and under the supervision of the physicians mentioned in this bill. As this bill is laudably intended to expand access to services, especially during a pandemic, and as PAs work with the physicians mentioned in the bill, this bill would be strengthened by including PAs.

5) **RELATED LEGISLATION.**

   a) AB 2360 (Maienschein) requires health care service plan or insurer to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist during standard provider hours, which may include evenings and weekends. AB 2360 is pending in Assembly Health Committee.

   b) AB 2624 (Aguiar-Curry) establishes a grant program for purposes of establishing and funding a statewide pediatric behavioral telehealth network, subject to a competitive grant process. AB 2624 is pending in Assembly Health Committee.

   c) SB 66 (Atkins) requires Medi-Cal reimbursement to FQHCs and RHCs for two visits taking place on the same day at a single location when the patient suffers illness or injury requiring additional diagnosis or treatment after the first visit, or when the patient has a medical visit and another health visit with a mental health or dental provider. SB 66 is on the Assembly Floor inactive file.

6) **PREVIOUS LEGISLATION.**

   a) AB 744 (Aguiar-Curry), Chapter 867, Statutes of 2019, requires health care contracts on or after January 1, 2021, to specify that the health plan or insurer is required to cover and reimburse diagnosis, consultation, or treatment delivered through telehealth on the same basis and to the same extent that the health plan or insurer is responsible for coverage and

reimbursement for the same service provided through in-person diagnosis, consultation, or treatment. AB 744 also broadened the store and forward Medi-Cal provisions by replacing the specific services of teleophthalmology, teledermatology, and teledentistry provided by asynchronous store and forward with the broader "for health care services" provided by asynchronous store and forward. Updates other telehealth provisions in existing law.

b) AB 1676 (Maienschein) of 2019 would have required health plans and health insurers, by January 1, 2021, to establish a telehealth consultation program that provides providers who treat children and pregnant and postpartum persons with access to a psychiatrist, as specified, in order to more quickly diagnose and treat children and pregnant and postpartum persons suffering from mental illness. AB 1676 was held on suspense in the Assembly Appropriations Committee.

c) SB 1023 (Hernandez) of 2018 would have required the Family Planning, Access, Care, and Treatment (PACT) program to cover services provided by a Family PACT provider through direct video and telephonic communications with a provider and direct or asynchronous care provided through a smart phone application that is appropriate to be delivered remotely based on current clinical guidelines. SB 1023 died in the Assembly inactive file.

d) AB 2861 (Salas), Chapter 500, Statutes of 2018, requires a drug Medi-Cal certified provider to receive reimbursement for individual counseling services provided through telehealth, as defined, by a licensed practitioner of the healing arts or registered or certified alcohol or other drug counselor, when medically necessary and in accordance with the Medicaid state plan, to the extent federal financial participation is available and any necessary federal approvals have been obtained.

e) AB 205 (Wood), Chapter 738, Statutes of 2017, authorizes the use of clinically appropriate telecommunications technology, including telehealth, as a means of determining annual compliance with the time and distance standards established in the bill or the DHCS's approval of a request for alternative access standards.

f) SB 171 (Hernandez), Chapter 768, Statutes of 2017, requires DHCS to ensure that all covered mental health benefits and substance use disorder benefits are provided in compliance with federal mental health parity regulations for Medicaid, and any subsequent amendment to those regulations, and any associated federal policy guidance issued by the federal Centers for Medicare and Medicaid Services.

g) AB 2507 (Gordon) of 2016 would have added video communications and telephone communications to the definition of telehealth. AB 2507 would have provided that the required prior consent for telehealth services may be digital as well as oral or written. AB 2507 was held in the Assembly Appropriations Committee.

h) SB 289 (Mitchell) of 2015 would have required health plans or health insurers to cover telephonic and electronic patient management services provided by a physician or non-physician health care provider and reimburse those services based on their complexity and time expenditure. SB 289 was held in the Senate Appropriations Committee.

i) AB 1771 (V. Manuel Pérez) of 2014 would have required health plans and health insurers, with respect to plan contracts and insurance policies issued, amended, or renewed on or after January 1, 2016, to cover telephone visits provided by a physician. AB 1771 was held in the Senate Appropriations Committee.

j) AB 809 (Logue), Chapter 404, Statutes of 2014, revises the informed consent requirements relating to the delivery of health care via telehealth by permitting consent to be made verbally or in writing, and by deleting the requirement that the health care provider who obtains the consent be at the originating site where the patient is physically located.

k) AB 1733 (Logue), Chapter 782, Statutes of 2012, specifies that the prohibition on requiring in-person contact also applies to other health care service plan contracts with the DHCS for services under the Medi-Cal program, and publicly supported programs other than Medi-Cal, as well as to the organizations implementing Programs of All-Inclusive Care for the Elderly.

l) AB 415, among other provisions, prohibits DHCS from requiring that a health care provider document a barrier to an in-person visit prior to paying for services provided via telehealth to a Medi-Cal beneficiary. Repeals the prohibition of paying for a service provided by telephone or facsimile and would instead prohibit DHCS from limiting the type of setting where services are provided for the patient. Prohibits health plans and insurers from requiring that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms of the relevant contract. Repeals the prohibition for paying for a service provided by telephone or facsimile and would instead prohibit health plans and insurers from limiting the type of setting where services are provided for the patient or by the health care provider.

m) SB 1665 (Thompson), Chapter 864, Statutes of 1996, established the Telemedicine Development Act (TDA) to set standards for the use of telemedicine by health care practitioners and insurers. TDA specifies, in part, that face-to-face contact between a health care provider and a patient shall not be required under the Medi-Cal program for services appropriately provided through telemedicine, when those services are otherwise covered by the Medi-Cal program, and requires a health care practitioner to obtain verbal and written consent prior to providing services through telemedicine.

REGISTERED SUPPORT / OPPOSITION:

Support

California Dental Association (cosponsor)
CaliforniaHealth+ Advocates (cosponsor)
Children Now (cosponsor)
The Children's Partnership (cosponsor)
Ochin, Inc. (cosponsor)
AARP
Alameda Health Consortium
Altamed Health Services Corporation
APLA Health
Arroyo Vista Family Health Center

Asian Health Services
Association of California Healthcare Districts
Bartz-altadonna Community Health Centers
Borrego Health
California Association of Marriage and Family Therapists
California Council of Community Behavioral Agencies
California Dental Hygienists Association
California Orthopedic Association
California Pan - Ethnic Health Network
California Podiatric Medical Association
California Psychological Association
California Telehealth Policy Coalition
Camarena Health
Central City Community Health Center
Chinatown Service Center
Clinica De Salud Del Valle De Salinas
Communicare Health Centers
Community Clinic Association of Los Angeles County
Community Health Systems, Inc.
Complete Care Community Health Center
Comprehensive Community Health Centers
Desert AIDS Project
District Hospital Leadership Forum
E-consult Workgroup
Essential Access Health
Families Together of Orange County
Family Health Care Centers of Greater Los Angeles, Inc.
First 5 Association of California
Health Alliance of Northern California
Health Center Partners of Southern California
Hill Country Health and Wellness Center
Inland Behavioral & Health Services
Justice in Aging
LA Clinica De La Raza, Inc.
Lifelong Medical Care
Los Angeles Christian Health Centers
Los Angeles LGBT Center
Los Angeles Trust for Children's Health
Marin Community Clinic
Mission City Community Network
National Association of Social Workers, California Chapter
Native American Health Center
Neighborhood Healthcare
North Coast Clinics Network
North County Health Project
North East Medical Services
Northeast Valley Health Corporation
Nurse - Family Partnership
Ole Health

Parktree Community Health Centers
Peachtree Health
Planned Parenthood Affiliates of California
Pomona Community Health Center
Queenscare Health Centers
Racial and Ethnic Mental Health Disparities Coalition
Redwood Community Health Coalition
Saban Community Clinic
Sacramento Native American Health Center
San Fernando Community Health Center
San Francisco Community Clinic Consortium
San Ysidro Health
Santa Rosa Community Health
Share Our Selves
Shasta Community Health Center
South Central Family Health Center
St. Johns Well Child & Family Health Center
St. Jude Neighborhood Health Center
Sutter Health
Tarzana Treatment Centers, Inc.
TCC Family Health
The Achievable Foundation
Tiburcio Vasquez Health Center, Inc.
UCLA Pediatric Dentistry
Umma Community Clinic
Valley Industry & Commerce Association
Venice Family Clinic
Via Care Community Health Center
Vista Community Clinic
Wellspace Health
Wesley Health Centers
West County Health Centers, Inc.
Wilmington Community Clinic

Opposition

None on file.

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